CODE	Section XII MEDICARE ORGANIZATION DETERMINATIONS & APPEALS Standard of 95 percent relates to requirements of timeliness, accuracy and disclosure. Use Worksheet: WS-AP1, AP2, AP3	YES	NO	NOTE
AP01	The MCO establishes, maintains, and follows the appeal procedures and procedures for expedited reviews and informs all enrollees in writing of the appeal procedures and procedures for expedited organization determinations. 42 CFR 417.600, 42 CFR 417.604; 417.609; 417.617 [ ] MET [ ] NOT MET			
AP02	The MCO's EOC properly defines and identifies organization determinations, i.e.,: • reimbursement for emergency or urgently needed services; • services furnished by nonaffiliated providers or suppliers that the enrollee believes are covered by the MCO contract and should have been furnished, arranged for, or reimbursed by the MCO; • services which the MCO refuses to provide that the enrollee believes should be furnished or arranged for by the MCO and the enrollee has not received outside the MCO; and • discontinuation or reduction of a service. 42 CFR 417.606 [ ] MET [ ] NOT MET			
AP03	The MCO makes an organization determination (the MCO's decision to provide, authorize, deny, pay for a service, or the discontinuation or reduction of a service) within 60 days or 72 hours of the enrollee's request for the service, or within 60 days of the enrollee's request for payment of a service. Failure to provide a notice constitutes an adverse organization determination which the enrollee may appeal (i.e., the situation is deemed adverse). 42 CFR 417.606; 417.608(c); 417.609(b) [ ] MET [ ] NOT MET			

AP04	**All adverse organization determinations must be in writing. The MCO's decision to deny payment for claims or refusal to provide or authorize a service is an adverse organization determination. In addition, an organization determination to discontinue inpatient services, i.e., hospitals or skilled nursing facility, must be in writing. (Note: Not every service reduction is adverse. Therefore, written notice not required for reduction, unless objection raised.)** **A written notice of adverse organization determinations and discontinuation of inpatient services:** • **states the specific reasons for the denial;** • **informs the enrollee of his/her right to a reconsideration, including the right to an expedited reconsideration; (Expedited reconsideration not applicable to denied claims.)** • **provides parties to the reconsideration reasonable opportunity to present evidence relating to the issue in dispute, in person as well as in writing;** • **specifies who may file a reconsideration;** • **includes information explaining that physicians and other health professionals may act on behalf of an enrollee in time-sensitive situations;** • **explains the 60-day appeal process;** • **explains the 72 hours expedited appeal process for appeals not related to claims;** • **informs the beneficiary of the opportunity to present evidence;** • **suggests information for supporting an appeal;** • **instructs beneficiaries how to obtain help with filing an appeal;** • **describes the PRO quality complaint process;** • **describes the MCO quality complaint process; and** • **informs members of the need for representative statement or waiver.** **42 CFR 417.608 and 417.618; CHPP/HPPA 7/22/1997 memorandum to health plans [ ] MET [ ] NOT MET**			
AP05	**The MCO develops procedures to assure that contracted providers are fully informed of appeal procedures and the providers' responsibility to provide written notice of adverse organization determinations to the enrollee when: 1) a service or payment is denied; 2) an enrollee objects to the reduction of a service, or 3) inpatient care is discontinued. The MCO monitors these procedures.** **42 CFR 417.606; 417.440(f) [ ] MET [ ] NOT MET**			
AP06	**The MCO accepts requests for reconsiderations and expedited reconsiderations filed within 60 days of the organization determination (or if good cause is shown, accepts reconsiderations filed after 60 days).** **42 CFR 417.616(b); 417.616(c) [ ] MET [ ] NOT MET**			
AP07	**The MCO assures that someone not involved in making the organization determination makes the reconsidered determination (first level of appeal of an adverse organization determination).** **42 CFR 417.622(b) [ ] MET [ ] NOT MET**			

AP08	**The MCO either makes a fully favorable decision and issues a decision to the enrollee within 60 days, or, if the MCO is unable to make a fully favorable decision, the MCO forwards the case to HCFA's contractor within 60 days from date of receipt of the reconsideration request and concurrently notifies the beneficiary of the action.** **42 CFR 417.620(c) and 417.620(f)** **[ ] MET [ ] NOT MET**			
AP09	**If the reconsidered determination is to hold the MCO liable, then the MCO provides or pays for the service within 60 days from the date of the reconsidered determination.** **Article IV, Section S, Medicare Contract.** **[ ] MET [ ] NOT MET**			
MOE	An organization determination is the MCO's decision to provide, authorize, deny, reduce, pay for, or discontinue services being furnished by the MCO. The MCO must inform enrollees of the need for a representative statement when the enrollee uses a representative. The MCO must inform the noncontracted physician/provider of the need for a waiver of payment statements when he or she files on his or her own behalf. Language used in expedited notices should reflect model language provided in 7/22/97 memoranda from CHPP. Expedited reconsideration requests can be presented orally or in writing and are filed directly with the MCO. **Determine**: ❑ whether the MCO's staff: 1) have procedures for adverse organization determinations; 2) are aware of and correctly distinguish issues subject to the Medicare appeal process and those subject to the grievance process; and 3) are aware of and can correctly distinguish issues subject to the standard 60-day Medicare appeal process and the 72-hour expedited appeal process, which includes oral requests. ❑ if the MCO provides notice to beneficiaries: 1) when inpatient, i.e., hospital and SNF, care is terminated, even if enrollee does not object to termination of care, 2) for all denials of service or payment, and 3) other circumstances when the enrollee objects. ❑ whether the MCO processes standard and expedited appeal cases within required time frames. **Review**: ❑ MCO's subscriber agreement, evidence of coverage, marketing material that describes appeal procedures, including expedited appeal procedures. (See MK09, MK10, MK11, & marketing material review log. Materials should have been reviewed during ongoing marketing review.) ❑ Denial notices/notices of noncoverage, and other outgoing correspondence for appropriate appeal language. **Continued next page**			

MOE con't.	❑ Contracting providers' procedures to determine how the MCO deals with denials of service and complaints that are organization determinations. In conjunction with this, examine the provider manual to ensure that clear, written instructions are given to providers and suppliers. If the appeal function is delegated, does the MCO have a written procedure to monitor the appeal process? ❑ Telephone and complaint logs; note time frames for addressing enrollee complaints. ❑ Enrollee concerns to determine whether they are correctly identified and referred to the appropriate department. ❑ Appeal cases processed by the MCO for accuracy and timeliness of the determination. ❑ Cases referred to HCFA's contractor for timeliness of referral and timeliness of effectuation of overturned decision. ❑ CHDR records. Prior to site visit, contact the Central Office CHDR project officer regarding MCO's record on reversals of reconsideration cases and request (if CHDR reports not already received). A high turnover rate raises questions as to whether there are problems related to informing enrollees, availability/accessibility of services, quality assurance, etc. Coordinate with other review sections, as appropriate. **Interview**: Staff who receive and process enrollee complaints. **NOTE RELATED TO AP01 - AP09**: Applies to Organization Determinations: AP01, AP02, AP03, AP04, AP05 Applies to Appeals: AP01, AP05, AP06, AP07, AP08, AP09 Applies to Expedited Organization Determinations: AP01 Applies to Expedited Appeals: AP01 **NOTE RELATED TO AP04: In order to have a MET for AP04, the notice must include all requirements listed in the element.** **NOTE RELATED TO AP08:** While the MCO must not issue an unfavorable decision, it must notify beneficiaries that their appeal is not being forwarded to the HCFA contractor. **NOTE RELATED TO AP09 & AP12:** AP09 addresses compliance with a determination of a standard reconsideration and AP12 addresses compliance with a determination of an expedited reconsideration.			
EXPEDITED ORGANIZATION DETERMINATIONS & EXPEDITED APPEALS				
AP10	**The MCO conducts an expedited review when either a contracting or a noncontracting physician requests an expedited organization determination or expedited reconsideration (physician must be appointed as a representative to request reconsideration).** **42 CFR 417.604(b)(4) , 417.609(c)(4), 417.617(c)(4)** **[ ] N/A [ ] MET [ ] NOT MET**			
AP11	**The MCO makes its appeal decision within 72 hours, unless a 10-day extension is permitted or MCO is waiting for medical records from noncontracting providers; if the decision is not fully favorable to the beneficiary, the MCO sends the appeal case to HCFA's contractor within 24 hours.** **42 CFR 417.620** **[ ] MET [ ] NOT MET**			

AP12	**The MCO complies with the reversal of the adverse organization determination, as medically indicated, but no later than 30 days.** **7/22/97 Memorandum Questions and Answers** **[ ] MET [ ] NOT MET**			
MOE	**<u>NOTE RELATED TO AP10 - AP12</u>:** ● **Applies to Expedited Organization Determinations: AP10** ● **Applies to Expedited Appeals: AP10, AP11, AP12** **MCO must expedite expedited review requests that are: 1) filed by a physician on behalf of enrollee (needs representative statement); 2) an enrollee-requested appeal when accompanied by a physician statement of support (oral or written) of the expedited reconsideration; 3) an inpatient termination of care (unless covered under the PRO process); 4) a discontinuation of physical therapy, regardless of setting; 5) a noncontracted physician request, where a waiver of liability is provided; 6) enrollee-filed appeals which the MCO decides to expedite. All of the above MCO expedited appeals and decisions not to expedite must be processed and enrollee/representative notified within 72 hours of the request (or expiration of extension).** **MCO must demonstrate, i.e., by documented files, the fact that enrollee is given an opportunity to present evidence and his or her response to this invitation. Expedited appeals may <u>not</u> be filed with Social Security Administration (SSA) District Offices (DO) or the Railroad Retirement Board (RRB). Begin counting the processing time for expedited appeals from 1) the date of receipt (in the MCO's designated department) of expedited review request, or 2) from the date of medical record receipt from noncontracted provider or supplier.** **Begin counting the processing time for expedited appeals. from 1) the date of receipt (in the MCO's designated department) of expedited review request, or 2) from the date of medical record receipt from noncontracted provider or supplier. For cases where the MCO must receive medical information from a physician or provider not affiliated with the MCO, the MCO's 72-hour processing time standard begins with receipt of the information in the MCO's designated department.** **NOTE:** ● **All appeals regarding discontiuation of inpatient hospital services (including rehabiliatation and phychiatric care) should be appealed to the PRO if enrollee is able to file timely; i.e., by noon of the first working day after receipt of written notice of noncoverage.**			

MOE cont.	• **Otherwise, process expedited appeal fro enrollees who miss the PRO deadline.** • **Enrollees appealing termination of SNF services, such as physical therapy, either as an outpatient service or in the home, must be expedited.**